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A Total Hearing Conservation Program *

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Twenty-four years ago the American Society for the Hard of Hearing (now the American Hearing Society) instigated a testing survey designed to locate every child with defective hearing, and particularly those in need of special assistance because of their hearing loss. This marked the birth of hearing conservation programs in America. The full impact of this survey was felt from Maine to California and from the Great Lakes to the Gulf Coast. This, and subsequent surveys, have resulted in the accumulation of certain data which indicated that there were, and are today, approximately $1\frac{1}{2}$ to 3 million children of school age in the nation with defective hearing. Incidence of hearing loss among children, however, appears to vary according to geographical location, climatic conditions, and the socio-economic status of the family.

Program Objectives

Although the original intent in the development of conservation of hearing programs was directed primarily toward finding children with defective hearing to determine their educational needs, the objectives of the program have expanded to include modern techniques in case-finding, adequate diagnosis, the provision of necessary medical and surgical care, the selection of hearing aids, the provision of special educational facilities, and guidance. No hearing conservation program is complete without full consideration of these factors. No efficient and complete program can be established

without basic planning, which in turn must be related to existing facilities and programs concerned with the over-all health and welfare of school-aged children.

Basic Planning

Before any state, county or city attempts to establish a hearing conservation program it is essential that all interested agencies, community groups, representatives of the local medical profession, and departments of health and education meet together to discuss purposes and objectives of the program. Some of the major colleges and universities have included in their speech department curricula related to the problems of the acoustically handicapped. These institutions might be used as a focal point for the development of a city, county or state-wide program, particularly with regard to those phases of the program which pertain to the rehabilitation and education of the acoustically handicapped.

State-wide planning calls for the coordinated efforts of the departments of education and health and the full cooperation of state and local medical groups. In California, for example, an advisory committee on the conservation of hearing was appointed by the California Medical Association to assist in planning medical aspects of the hearing program. The State Department of Education, primarily interested in the education of the hard of hearing child and in the recruitment and training of special teachers, has included a Consultant in the Education of the Hard of Hearing in its Bureau of Special Education. The State Department of Public Health, in order to carry out the provisions of the Crippled Children's Act, which includes acoustically

* Presented at the annual meeting of the American School Health Association in New York, October 24, 1949. Printed here by permission of the American School Health Association.

handicapped, established the position of Hearing Conservation Specialist. This person acts as a consultant to local health and school departments, assisting them in the development of their case-finding programs, with organization of otological, diagnostic and treatment clinics which are provided through Crippled Children Services, and with the selection of hearing aids for the more severely handicapped.

Case Finding

Case-finding methods employed in the schools are described in detail in a syllabus of audiometric procedures prepared in 1945 by the Committee on Conservation of Hearing, The American Academy of Ophthalmology and Otolaryngology. This syllabus has been accepted as a guide in the development of case-finding programs throughout the United States.

The first objective of any hearing program is to locate all children who may need special education or medical services related to hearing impairment. The most widely used screening method has been with the four-type speech phonograph audiometer. With the exception of a few minor changes, this instrument is the same type as that used many years ago. Its carefully calibrated records, which produce pairs of numbers of diminishing intensity, enable the tester to screen test as many as 40 children at a time. Those who use the four-type audiometer should never lose sight of the fact that it is a test of the "conventional speech range" and not a diagnostic audiometric test of hearing.

Another method of screening, developed in recent years, is the "sweep frequency" pure-tone screening test. This test is administered individually and enables the audiometrist to rapidly determine an individual's hearing acuity throughout an audiometric range from 128 (or 256) through 8192 (or 11,584) cycles per second. This range of hearing extends well above and below the accepted conversational speech range.

The Massachusetts Department of Public Health has developed a testing technique called the Massachusetts Hearing Test, incorporating the use of the pure-tone audiometer coupled with group audiometer receivers.

A detailed explanation of this testing technique can be found in the *Journal of the Acoustical Society of America*, September, 1948. It is believed that this new method of testing will enable an audiometrist to screen large numbers of children more efficiently than with other methods previously discussed.

Some study has been made of the relative advantages and disadvantages of the testing methods mentioned above. In group testing considerable time is required for setting up the equipment, for explanation

and administration of the test, and for scoring test record sheets. The conducting of any group audiometer test calls for a quiet room which will accommodate up to 40 children. Also, because it is impractical to test children below the third grade with this instrument, and because of the difficulty certain children may have in writing the numbers, this test may not meet the needs of a total program. It is of considerable value for screen testing large numbers of children above the third grade, and particularly in locating those children who might have difficulty hearing in the classroom. Recommended procedures in conducting this type of test advise retests on the same instrument for those who fail the initial test. Furthermore, it is recommended that children who fail the group test be given a pure-tone threshold hearing test before they are referred for medical examination.

Past experience has demonstrated that group tests often result in the over-referral of children. This is probably related to the lack of adequate training which should be given every technician. On the other hand, it is estimated that between 25 and 50 percent of children with losses of hearing above 2,048 cycles per second are missed when tested with the phonograph type audiometer. To alleviate these discrepancies, teacher and nurse observations of the child's behavior, his speech patterns, school achievement, and other conditions which might indicate a possible hearing loss are of inestimable value to the audiometrist.

The pure-tone "sweep frequency" test is one which requires simple administrative techniques. A small, quiet room, one which will accommodate three or four persons, is adequate. Although the test is administered individually, the actual per capita time consumed, including setting up of apparatus, instructions to children, and scoring of test is about equal for both group and "sweep frequency" testing. The average time required for an individual "sweep frequency" test is approximately one to one and one-half minutes per child. Successful screening tests of this type have been administered to children as young as four years of age. In conducting this pure-tone screening test, the suggested attenuation for each frequency is ten or fifteen decibels, depending upon the extent of room noises which prevail. Children who fail to hear any one of the frequencies are referred directly for a pure-tone threshold test.

Threshold of Acuity Tests

The pure-tone audiometer is the accepted instrument to be used in determining an accurate measurement of hearing acuity. The United States Bureau of

Standards and the Council on Physical Medicine, American Medical Association, have cooperated in establishing certain standards of acceptance for pure-tone audiometers. It is suggested that school audiometrists use only those instruments which have been accepted by the Council on Physical Medicine.

The results of a pure-tone audiometer test serve as a diagnostic tool in the hands of a competent physician or otologist. Audiologists and other well-trained persons in the field of education of the acoustically handicapped are often able to use these test results as a means of determining the educational needs of the child.

Importance of Otological Diagnosis

The discussion of testing methods has indicated that a hearing conservation program is not concerned solely with the special educational facilities. The preventive aspects of the program are of primary importance also. When one studies large groups of hard of hearing people he soon learns that nearly half of them would not be handicapped if conditions causing their hearing loss had been determined in early childhood. Careful case-finding is a method of developing the preventive and remedial phases of the program. Every child whose pure-tone audiometric test indicates a loss of 20 or more decibels in one or more frequencies should be examined by a qualified physician, preferably by an otolaryngologist. The examining physician may be able to determine the presence of certain conditions which are amenable to treatment. In these cases loss of hearing can be arrested or restored if the condition is properly diagnosed and the child receives expert medical or surgical care. According to leading otologists, approximately 75 percent of the children whose hearing deviates from the established normal threshold of acuity can benefit from such a program.

Not all children with defective hearing have difficulty in hearing conversational speech. Care must therefore be taken when explaining a test result to the parent or to the teacher. The examining physician should explain the loss of hearing and its relationship to the existing pathology which might be a causative factor.

Medical Follow-up

More than 80 percent of children seen at the otological diagnostic clinics in California have received recommendations for medical or surgical care, or both. Many of these children are cared for by private physicians. Others are considered for care through the State Crippled Children's Program, funds for which are provided through local taxation and supplementary state and federal allotments. This program also provides for the purchase of hearing aids when recommended by the

otologist. In some areas hearing centers are being established where persons may go for an evaluation and selection of hearing aids. These centers are usually sponsored by universities which have schools of medicine, or by local hearing societies.

Education and Guidance

It is important that each child whose audiometric test indicates a hearing loss should be considered a possible candidate for special education and environmental adjustment in the classroom. Such measures will vary according to the degree of hearing loss and the existing facilities. The classroom teacher should be made cognizant of any child in her classroom who has a hearing loss. There is no specific category into which children with defective hearing can be placed. Each case must be considered individually. A child with a hearing loss in the speech range, whether such loss involves one ear or both, should be allowed to sit in the classroom where he can hear and see the teacher. Some schools have found it valuable to permit the hard-of-hearing child to change his seat from time to time, thus enabling him to participate in all activities. Teachers should be given special instructions with regard to helping the hard-of-hearing child in the classroom. Special instructions should also be given the parents so that they may help the child at home. Lip reading, speech, and auditory training for those children who are more severely handicapped should be made available.

Vocational, psychological and educational guidance is the responsibility of the school administration. Counselors and teachers should be aware of the handicap of deafness and of the socio-economic implications of deafness in order that they can advise and direct the child with defective hearing into avenues of gainful employment. The success of any educational and guidance program for the physically handicapped is measured only by the achievement of the individual after he leaves the school environment.

Conclusion

Educational, medical, technical and psychological advancement in recent years have caused this Nation to recognize deafness, not as a handicap, but as a condition which can be dealt with scientifically and with concrete results. Hearing conservation programs are economically sound in that they ultimately reduce the excessive costs incurred by the school districts as the result of grade repetition. Good hearing is essential to a full life. A hearing handicap often retards an individual in his mental, emotional and social development. Therefore, a total hearing conservation program, when planned and conducted efficiently, will result in the gradual decline in numbers of acoustically handicapped

individuals and will assist the more severely handicapped to take their place in the hearing world of which they are a part.

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Civil Service Examinations

Sanitary Inspector: The California State Personnel Board announces an examination for *Sanitary Inspector* on May 18th. Final date for filing is April 27th. Applicants must possess a certificate of registration as a sanitarian in California and must have been residents of this State for at least one year. Salary range is \$255 to \$310. Additional information is available from the State Personnel Board, 1015 L Street, Sacramento.

Bacteriologist: This examination has been postponed by the State Personnel Board from March 18th to April 29th. The closing date for filing applications has been extended to April 8th. Salary range is \$243 to \$295. The majority of positions are in Berkeley. Applicants must possess a public health bacteriologist's certificate issued by the State Department of Public Health. Educational requirements are graduation from college with major work in bacteriology, virology, medical laboratory technology, or public health. (Clinical bacteriological laboratory experience may be substituted for the required education on a year-to-year basis.)

Border Public Health Meeting

Health officers in border states of both the United States and Mexico are invited to attend the annual meeting of the United States-Mexico Border Public Health Association April 12th to 14th in Chihuahua, Mexico, south of El Paso. Discussions will be directed toward solution of a number of difficult border public health problems. Reservations may be made with Dr. M. F. Haralson, secretary of the association, 314 U. S. Courthouse, El Paso.

Local Health Services Bill Pending in Congress

H. R. 5865, a bill authorizing financial assistance to local health departments across the Nation, is now pending before the Committee on Interstate and Foreign Commerce of the House, on which California is represented by the Honorable Carl Henshaw of Pasadena. Although there is no apparent opposition to the Local Health Services Act, it may not pass for lack of active support. S. 522, companion bill to H. R. 5865, has been passed by the Senate.

The California Conference of Local Health Officers and its Committee on Administrative Practices have adopted resolutions supporting this legislation. California would receive approximately \$0.38 per capita from funds provided by the bill.

H. R. 5865 has the support of such professional organizations as the American Medical Association, American Public Health Association, Association of State and Territorial Health Officers, American Academy of Pediatrics, and the National Organization for Public Health Nursing. National voluntary health agencies and numerous citizen groups such as the National Congress of Parents and Teachers have also given the bill their active endorsement.

Main provisions of the bill are summarized as follows:

1. H. R. 5865 is the bill substantially in the form in which the Local Health Units Act of 1948 was reported out favorably by the House Committee on Interstate and Foreign Commerce of the Eightieth Congress.
2. It authorizes federal grants-in-aid specifically for local public health departments.
3. The health services for which federal funds are authorized include at least the six minimum functions of a local health department: Vital statistics, communicable disease control, maternity and child hygiene services, environmental sanitation, public health laboratory services, and public health education.
4. The act provides that for the Nation as a whole the federal share of expenditures of local health units shall be one-third of such expenditures up to \$1.50 per capita annually. For individual states and individual localities it may vary with the per capita income of the State up to two-thirds of the \$1.50 per capita expenditure.
5. It provides for the channeling of funds to local health departments, to be administered locally, and requires only that basic minimum standards be met in the operation of local health departments.

stipulates that state and local areas assume responsibility for substantial support of local health departments.

6. Like the Hospital Construction Act, it requires, before funds are granted, that a state plan be submitted by the state health department which looks forward to the systematic coverage of all areas within the State by full time local health departments.
7. It authorizes funds for training purposes to alleviate the present acute shortage of professional public health personnel.

Industrial Safety Conference

Comprehensive plans for reducing California's high toll of industrial injuries will be submitted to some 2,000 leaders in labor and management scheduled to attend the Governor's Industrial Safety Conference in Los Angeles April 12th and 13th. Governor Warren will be the keynote speaker. For five months action committees from industry have been studying occupational injury problems, reaching in that period nearly every industrial plant in the State in preparation for a positive accident-prevention program.

An immediate objective for 1950 calls for a 25 percent reduction in the occupational injury toll. Last year this toll was 649 deaths and 142,177 disabling injuries in California industry.

Paul Scharrenberg, State Director of Industrial Relations, will be conference chairman.

Phosphate Poisoning Reprint

An article by Dr. Alvin R. Leonard entitled "Organic Phosphate Poisoning," which appeared in the January 31st issue of *California's Health*, is to receive nation-wide circulation in *The Sanitarian*, official magazine of the National Association of Sanitarians. Permission to reprint was requested by Mr. Charles E. Steele, Los Angeles, acting managing editor of *The Sanitarian*. At the time the article was written, Dr. Leonard, now assistant director of the San Diego City-County Health Department, was a medical officer in the Bureau of Adult Health.

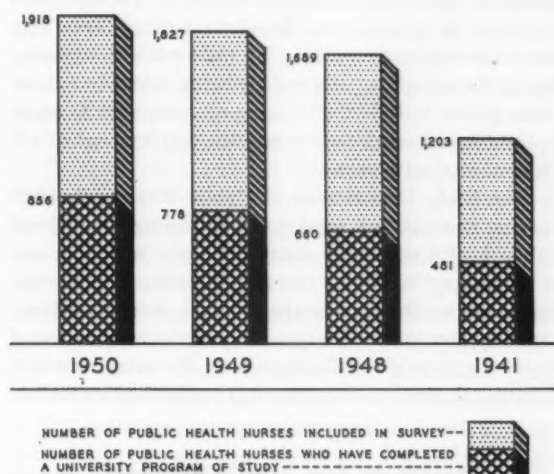
Reservations for Heart Meeting

The American Heart Association, which will hold its annual meeting in San Francisco June 22d-25th, just ahead of the annual meeting here of the American Medical Society, announces that those desiring to make hotel reservations for the conference must make application through the Hotel Committee of the American Medical Association, Convention Bureau, 200 Civic Auditorium, San Francisco 2.

Annual Public Health Nursing Count Shows Continued Increase

The number of nurses engaged in public health work in California has reached 2,000 and, for the first time since before the war, every county in the State has the benefit of service provided by at least one public health nurse. The annual count of nurses employed as of January 1, 1950, was made by the Bureau of Public Health

CALIFORNIA PUBLIC HEALTH NURSING SURVEY



SOURCE:----- STATE OF CALIFORNIA-----DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH NURSING RECORDS - ANNUAL COUNT AS OF JANUARY 1 EACH YR.

Nursing. Figures compiled by the bureau also show an additional 618 nurses employed in industry.

Almost half of the 2,000 nurses are employed by local health departments. School health programs operated by Boards of Education employ the next largest group, while most of the remainder are employed in such nonofficial agencies as visiting nurse associations.

The numerical distribution of nurses in 1949 and 1950 is shown in the following table:

Type of Agency	No. of Agencies		No. of Nurses	
	1949	1950	1949	1950
State	1	2	19	23
Local				
Health departments	50	53	874	917
Boards of education	295	319	766	814
Other official agencies	7	5	10	8
Nonofficial agencies	36	34	228	233
Schools of nursing	2	5	2	5
Totals	392	418	1902	2000
Industries	357	368	602	618

Concurrent with each annual count, a study has also been made of the educational qualifications of public health nurses. The first study was made in 1941. The following table compares 1941 with 1950 in regards

to the numbers and percent of nurses who had completed a university program of study in public health nursing and those who hold a college degree:

	1941		1950	
	Number	Percent	Number	Percent
Employed in public health nursing	1,203	100.0	2,000	100.0
Included in study	1,157	96.2	1,918	95.8
University program of study in PHN	481	41.6	856	45.0
College degree	297	25.6	665	34.2

Population increase has outdistanced the increase in numbers of public health nurses serving California residents. Agencies are keenly aware of the continued shortage of nurses. One hundred twenty-three registered nurses are employed by public health agencies for clinic activities. Other steps being taken to extend nurse power include the training of volunteers to assist in child health conferences, and the employment of additional clerical personnel.

The State Department of Public Health, through nursing consultation service, is continuing to aid local public health nurses in analyzing their activities and in promoting in-service training in order to make the best use of available personnel. Nurses are continuously urged to obtain preparation for public health nursing at the University of California in Berkeley and Los Angeles. Nurses are also recruited from other states.

Institute for Administrators

University College of Northwestern University, in cooperation with the Public Health Service, announces an institute in administration for public health officials for July 17th to 29th on the university campus, Chicago. This institute, designed for principal administrative officers of state and local health departments, is similar to one held in the summer of 1948. Registration is restricted to health officials with managerial responsibilities and opportunities. The session will deal chiefly with administrative problems and trends encountered by the public health physician. Full details may be obtained from Dean E. T. McSwain, 710 Lake Shore Drive, Chicago 11.

Doctor Leonard Takes San Diego Post

Dr. Alvin R. Leonard of the Bureau of Adult Health, has resigned from the state staff to accept the position of assistant director of the San Diego City-County Health Department. The San Diego position became open last July when Dr. J. B. Askew, then assistant director, was appointed San Diego Health Officer following the retirement of Dr. Alex Lesem. Doctor Leonard had served on the medical staff of the Bureau of Adult Health for 18 months.

Los Angeles Air Pollution Report Issued by District

Second-year activities of the Los Angeles Air Pollution Control District for the Fiscal Year 1948-49 are summarized in the following statistics which appear in the districts's annual report recently published:

Number of inspections	19,159
Number of written notices issued	3,386
Number of improvements	2,582
Number of hearings	880
Number of complaints received against specific sources	797
Number of permits issued	595

Estimated value of air pollution control equipment for which the 595 permits were issued was listed at \$3,700,000. During the fiscal year, equipment actually installed for the control of air pollution was estimated to cost \$1,744,000.

The Los Angeles Air Pollution Control District was the first control district formed in California following enabling legislation by the State Legislature.

Change of Quarters, Fresno

Pending construction of a new health center now in the planning stage, the Fresno County Health Department under William F. Stein, M.D., has occupied temporary quarters on the grounds of the Fresno General Hospital. All services of the department were moved from the county courthouse to this location except milk inspection, sanitation services, and the public health laboratory, which remain at the old city health department headquarters.

Nursing Certificates Granted

During 1949 public health nursing certificates were issued to 276 nurses, 76 by examination and 200 upon submission of evidence of having completed an approved program of study in public health nursing. Of the 200, 94 had completed their preparation at the Berkeley and Los Angeles campuses of the University of California. The other 106 obtained their training in other states. Five of the 106 were California nurses who went outside the State for their university training.

San Diego Has New Bulletin

Popular presentation of program highlights features a new bulletin entitled *The San Diego Department of Public Health Reports*. The first issue is an illustrated interpretation of major departmental activities covering a three-month period. The San Diego Department of Public Health also publishes a monthly bulletin entitled *San Diego's Health*.

Maternal and Child Health Services Show Rapid Rise in State

A significant increase in preventive health services available to mothers and children in California is revealed in a study made by the Bureau of Maternal and Child Health comparing the Fiscal Year 1945-46 with 1948-49. In this period child health conference centers increased by 49 percent, from 373 centers in 37 counties and 11 cities of 50,000 or more population, to 559 centers in 41 counties and 13 cities of the same size. Similarly, the number of prenatal clinic centers increased by 92 percent, from 39 in 1945-46 to 75 in 1948-49.

An increase in sessions held at these centers showed that there was not only better geographic coverage, but also increased use of facilities which were established. The number of child health conference sessions rose from 10,415 in 1945-46 to 15,914 in 1948-49, an increase of 52 percent. Prenatal clinic sessions increased 60 percent, from 1399 to 2240.

A significant finding was the growing participation of local practicing physicians in the child health conference program. The number of sessions conducted by private physicians increased over 67 percent in 1948-49 as compared with 1945-46.

Undoubtedly, many factors enter into this growth in facilities, services and the participation of practicing physicians, among them the greater availability of professional personnel. This bureau study, however, is of particular interest because of the change in state financial participation in the development of local maternal and child health service.

Prior to 1947, federal funds made available to the State for maternal and child health services were specifically allocated to local areas. In 1947, the State Local Health Assistance Act provided a \$2,000,000 grant-in-aid subsidy for the development of local health services. The Conference of Local Health Officers recommended that federal grants for certain special programs be included with the state grant-in-aid subsidies.

Under this plan local health officers receiving these subsidies have responsibility for establishing and financing local health services. Maternal and child health services planned to meet community needs are included in the six basic services for which a local health department must plan in qualifying for these funds.

The actual allocation of federal maternal and child health funds by the State to local health departments decreased by 68 percent in 1948-49 as compared with 1945-46. This was offset by the great increase in general local health funds available to the counties, and would seem to indicate that the development of basic maternal

and child health services is not so dependent on special, earmarked funds as it is on the establishment and improved financing of full-time local health departments.

U. C. Summer Sessions to Offer Course in Lab Technics

A summer sessions course in Public Health Laboratory Technics will be offered on the Berkeley campus of the University of California for the first time this year to accommodate a heavy and unmet demand, both from laboratory technicians employed in clinical and public health laboratories and from major students in bacteriology, biochemistry and parasitology who have been unable to take the course in regular session due to large enrollments.

The course is listed by the Office of Summer Sessions as Public Health S150-B (formerly Hygiene 108—Public Health 151) and is open to students who have had an advance bacteriology course, or field experience. Enrollment is limited to 40 with admission upon consent of the instructor.

Class will convene Monday through Friday from 8 a.m. to 12, plus two afternoons of two hours each. The course extends through both summer sessions, June 19th to September 9th, and carries eight units of credit.

The course will include bacteriological and serological technics involved in laboratory diagnosis of diphtheria, salmonellosis, gonorrhea, infectious mononucleosis, shigellosis, syphilis, tuberculosis, and the examination of milk and water samples.

Before registering, one must file an application for summer sessions with the Office of Summer Sessions, Room 1, Administration Building, University of California, Berkeley 4. Fee is \$48 per session.

Mosquito Control Association Reports Conference

Modern progress in mosquito control in California, other states of the country, and in many foreign sections of the world is related in papers and proceedings of the 17th annual conference of the California Mosquito Control Association. The conference was held jointly with the American Mosquito Control Association in Berkeley in February.

California's progress in control work was presented to the conference by Mr. Arve H. Dahl, Chief, Bureau of Vector Control, Division of Environmental Sanitation of the State Department of Public Health.

The conference report is dedicated in memory of the late Professor W. B. Herms, "father of California Mosquito Control and Savant in Malariology." Professor Herms died in 1949.

Additional Federal Hospital Funds to Be Available in July

Additional federal funds for hospital and health facility construction in California will be available for allocation July 1, 1950. Hospitals and health departments which do not have applications on file and are desirous of receiving consideration during the coming fiscal year must submit their applications prior to May 31, 1950. These applications should be submitted to the California State Department of Public Health, attention Bureau of Hospitals, 760 Market Street, Room 360, San Francisco 2. The staff of the Bureau of Hospitals is available for discussion with local organizations and to assist in the preparation of applications.

The construction program makes available federal and, in some instances, state funds to assist in the construction and equipping of acute general, tuberculosis, chronic disease and mental hospitals, and public health facilities. Periodically, as funds are available, applications are approved in priority sequence based on consideration of areas where most acute needs exist. An Advisory Hospital Council, appointed by the Governor, participates with the Department of Public Health in making these allocations.

Forty-two California hospital construction projects have been sanctioned through funds approved by the State Advisory Hospital Council since the subsidy program began in July, 1947. The federal allocation for the 1949-50 Fiscal Year was \$5,147,909.

Applicants qualify for consideration by completing Part 1 of a project application, which simply makes the application a matter of record and is not a formal commitment on the part of the applicant. When allocations are made, the applicant is given a period of four months in which to demonstrate his ability to finance the local share of the cost of the project. When local funds are available, the local organization employs an architect and has plans drawn. Plans must comply with minimum federal requirements. The local group employs the builder and pays him, being reimbursed periodically after inspection by the state agency.

Voluntary nonprofit hospitals, publicly owned hospitals, and publicly owned health facilities qualify for assistance under the program. Assistance to voluntary hospitals is limited to a maximum of one-third federal funds. Public institutions may obtain a maximum of one-third federal funds and one-third state funds.

In allocating funds to projects it is the policy of the Department of Public Health and the Advisory Hospital Council to establish conservative maximum project amounts in which public funds will be allocated, with the understanding that if the local community

desires to construct a larger or more elaborate facility the additional cost will be borne 100 percent by local organization.

California Morbidity Report February, 1950

Civilian Cases

Reportable diseases	Week ending				Total cases	5-yr. median
	2/4	2/11	2/18	2/25	Feb.	1945-1949 Feb.
Amebiasis	6	3	2	8	19	11
Anthrax						
Botulism						
Brucellosis (undulant fever)	9	1			10	18
Chancre	1	9		7	26	38
Chickenpox	1,023	922	998	977	3,920	5,002
Cholera						
Coccidioidomycosis, disseminated	2	1	1	4	8	5
Conjunctivitis, acute infectious of newborn						2
Dengue						
Diarrhea of the newborn	3	5	1	1	10	2
Diphtheria	10	5	12	7	34	116
Encephalitis, infectious	1	5	2	2	10	5
Epilepsy	42	40	42	43	167	140
Food poisoning	1	13			14	35
German measles	68	66	67	48	249	1,991
Gonococcus infection	415	371	241	328	1,355	1,918
Granuloma inguinale	2	1		1	4	5
Hepatitis, infectious	7	4	8	3	22	20
Influenza, epidemic	38	25	5	23	91	163
Leprosy						1
Leptospirosis (Weil's disease)			1	1	2	18
Lymphogranuloma venereum						9
Malaria						
Measles	209	189	251	219	868	3,268
Meningitis, meningococcal	6	6	6	10	28	49
Mumps	1,101	724	874	1,074	3,773	2,324
Pertussis	157	144	186	86	573	406
Plague						
Pneumonia, infectious	71	56	76	53	256	227
Poliomyelitis, acute anterior	14	13	13	18	58	30
Psittacosis						1
Rabies, animal						22
Rabies, human						4
Relapsing fever						
Rheumatic fever, acute	6	11	9	29	55	63
Rocky Mountain spotted fever						
Salmonella infections*	3	5	2		10	2
Shigella infections (bacillary dysentery)	19	14	8	20	61	20
Smallpox						
Streptococcal infections:						
Scarlet fever	175	155	119	136	585	601
Streptococcal sore throat (and "septic sore throat")	10	28	10	31	79	47
Syphilis	233	193	178	190	794	1,811
Tetanus				1	2	5
Trachoma				1	1	
Trichinosis						
Tuberculosis:						
Respiratory	169	144	122	177	612	619
Other forms	7	4	10	4	25	35
Tularemia						
Typhoid fever	3	3			6	5
Typhus fever						
Yellow fever						
Totals					13,731	

* All types of Salmonella infections now reportable. Prior to January 1, 1949, only A, B and C types were reportable; hence five-year median not entirely comparable.

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